

A COUNSELLING INTERNSHIP AT THE PSYCHOLOGY
DEPARTMENT OF THE JANEWAY CHILD HEALTH
CENTER WITH A RESEARCH STUDY ON CLIENTS'
AND THERAPISTS' PERCEPTIONS OF SUCCESS
IN FAMILY THERAPY

CENTRE FOR NEWFOUNDLAND STUDIES

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WITH
A RESEARCH STUDY ON CLIENTS' AND THERAPISTS'
PERCEPTIONS OF SUCCESS IN FAMILY THERAPY**

BY

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**A report submitted to the School of Graduate Studies
In partial fulfillment of the requirements for the degree of
Master of Education**

**Faculty of Education
Memorial University of Newfoundland**

July, 1994

St. John's

Newfoundland



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Abstract

This report consists of two parts. The first section describes an internship completed at the Psychology Department of the Janeway Child Health Center, August 1993 to December 1993. It includes: a comprehensive report of the rationale for the internship; and a description of the setting, supervision, goals and professional activities of the intern during the internship placement. In addition this report describes a research project conducted during the internship. The research project studied the perceptions of clients' and therapists' as it relates to the outcome of family therapy. In order to assess the perceptions of success, the Family Assessment Device and a researcher prepared follow-up questionnaire for the clients and therapists were administered. Overall results of this research indicated that clients and therapists concur on the outcome of family therapy. There is also close agreement on the areas of improvement and the degree of success. Clients reported a high degree of satisfaction with therapy. The results of this study will be useful information for clients, therapists, and the research setting for future planning and programming of family therapy services.

Acknowledgements

I would like to thank Dr. Linda Moxley-Haegert for providing excellent field supervision during this internship. I am also grateful to the staff of the Janeway Child Health Center and in particular the Janeway Psychology Department for sharing their expertise with me.

To the families and children who provided me with a rich and rewarding experience, I extend my sincere thanks.

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To my friends, especially Judy Furlong-Mallard and Donna McLennon I offer many thanks for their tireless support and expertise.

To my family, especially my mother Rose, for her unconditional love always and to my mother-in-law Vivienne for her encouragement, I extend my sincere thanks.

To my husband Patrick and my children Christine, Elizabeth, Patrick, and Michael a heartfelt thank-you for your encouragement, support and love as I pursued this project. I love you.

This report is dedicated to all the families I have worked with over the past several years.

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CHAPTER 1

Rationale For An Internship

A counselling internship is an option available to graduate students in the Master Degree Program in Educational Psychology at Memorial University. The internship provides on the job experience in a wide range of professional activities. These are carried out under the supervision of a field supervisor and a university supervisor. The field setting serves to further develop competence of the counsellor and provides the opportunity to test counselling theories through practise. This practical experience thus promotes skill development with a good theoretical basis that can be transferred into effective delivery of counselling services within the school environment.

As stated in the Department of Educational Psychology Internship Guidelines (1975), "the nature, scope and specialization encompassed in the role of the counsellor requires intensive training, a considerable portion of which should be devoted to supervised experiential training". The American Psychology and Guidance Association defines an internship as:

... an on-the-job experience under systematic supervision and evaluation. It is usually a full time position serving as an extension of practical experience beyond the counselling practicum.

The role of the counsellor in Newfoundland schools has had to change to meet the unique needs of today's youth. A broad knowledge and skills based program offers the counsellor the learning experiences that go beyond that which could be offered through individual course work and a narrowly focused setting. Reaching beyond the scope of the required practicum for the Master Degree in Educational Psychology, this internship provided the counsellor with the opportunity to develop further competence in the areas of Individual and Group Counselling, Family Therapy, Assessment, Consultation and Liaison.

Based on the intern's own personal experience as a counsellor in the Newfoundland school system, it has become apparent to her that deficiencies exist in the training of counsellors to perform in the Newfoundland school system. Some of these include: training in family therapy; exposure to a broad variety of assessment devices and techniques; familiarity with the facilities and programs available in mental health for children and adolescents; and the multidisciplinary approaches to the management of psychological/psychiatric conditions in children and youth.

The internship was chosen by this student to provide indepth training in the skill areas necessary to execute the multi-faceted roles of a school counsellor in the province of Newfoundland. Besides providing the intern with exposure to a wide range of assessment and therapy techniques,

the setting of the Janeway Child Health Center enabled the intern to experience the helping profession within the medical setting. This has always been of interest to the intern having initially begun her career in the biological sciences.

The internship then seems to be a logical medium to provide adequate training which could not be obtained from completion of the Master Degree in Education Psychology and its requirement of a single practicum.

Setting For The Internship

As stated in the Department of Educational Psychology Paper on the Internship Program (1975), "the intern should work with a variety of clients appropriate to her eventual employment under conditions that protect the interest of the counselee as well as contribute to the competence of the intern."

The setting should provide experiences that are related to tasks judged to be part of the role contemplated by the intern in her initial vocational placement. There should be provision for assistance to the intern in integrating theory and practise. The experiences and time allotment should be sufficient to enable her to grow personally and professionally and to develop an appropriate level of skills.

As a counsellor in the Newfoundland urban school, the intern will

be addressing issues with students from the pre-school to Grade 12 level. These children and adolescents experience difficulties related to the family and the individual. The Janeway Child Health Center Psychology Department is a suitable setting for the school counsellor to conduct an internship.

The following factors were taken into considerations in selecting the internship setting:

1. The quality of professional supervision;
2. The quality of learning opportunities and experiences;
3. The relevancy to, and usefulness of such experiences in the actual setting in which the internee ultimately expects to work;
4. The availability of time for full-time involvement of the intern for a minimum of thirteen consecutive weeks;
5. Availability of a qualified field supervisor on-site; and
6. Ready access to the university supervisor.

The intern, having several years of experience as a school counsellor and realizing the need for specific experience in assessment and counselling, requested the Psychology Department at the Janeway Child Health Center as her setting. There are 4 full-time psychologists as well as several research assistants offering a wide range of services.

As stated in the Program Description Guide (November, 1993) of

The Janeway Child Health Center Psychology Department, help is offered through the following services:

- (1) Developmental Psychology Service. Developmental Psychology is the branch of science which is concerned with the origin and change in physical, mental, and social functioning that occurs throughout life.

On occasions, a young child does not progress along the expected pathway of development or he/she does not progress at the expected rate of development. These observed changes in either the rate or pattern of the development may be due to either genetic and/or congenital factors. The aim of the Developmental Service in Psychology at the Janeway is to assess the present developmental status of young infants or children who are suspected of exhibiting a slower rate of development or a pattern of development that is different than might be expected. Upon diagnosis of a significant developmental problem, appropriate stimulation activities can be formulated with the aim to reduce or delay or change the existing pattern of behavior and counselling with family may be implemented at this time. Counselling may be implemented in the form of parent groups, family therapy, behavior modification programs, or consultation with the preschools or a variety of other ways.

Most referrals for this program in psychology will come through the Child Development Program.

As well, at this moment in time this service will apply to those preschool children who would fall under neuropsychology which is the branch of psychology concerned with the study of brain and behavior or the relationship between the two. Clinical psychologists in this area generally assess adaptive abilities. The primary purpose of neuropsychology would be to provide a comprehensive description of a child's ability and relate this information to brain functioning. This information is used to help plan programs for the home and/or school.

Referrals for preschool neuropsychology are appropriate in the following circumstances:

- a. Where there is known or suspected neuropathology (epilepsy, head injury, Central Nervous System (CNS) infections, congenital neuroanatomical malfunctions);
 - b. Where there has been a recent marked alteration in performance, personality, or other aspects of adaptive functioning suggesting possible CNS involvement; and
 - c. Congenital syndromes associated with psychological or behavioral outcomes (ie, PKU, William's Syndrome, Turner's Syndrome).
- (2) Clinical Evaluation and Treatment. This services in responsible for

general evaluation and program planning for children aged five through sixteen years. This evaluation may be in terms of intelligence, school achievement, language skills, personality factors, adaptive behavioral, organizational capacities, and visual-spatial motor skills. Based on the results of the assessment, specific recommendations are made to the school and home.

A child is referred for psychoeducational assessment in the following cases only:

- a. The child has had an assessment and a second opinion is felt necessary (a retest interval of at least 6 months is requested); and
 - b. When assessment is necessary as pre-operative and post-operative evaluation or pre and post-therapy.
- (3) **Behavior Therapy Service.** Behavior Therapy involves the application of learning principles to every day problems. Research has shown that behavior therapy has proven application with child and adolescent disorders. The psychologist sets specific treatment goals which are intended to expand the parents' and/or child's skills and abilities. Treatment can include group and/or individual work with children and usually involves parent counselling.

Areas of services for behavior therapy are:

- * Chronic behavioral or medical conditions

- * Non-compliance to medical procedure
- * Eating disturbances
- * Exceptional children
- * Pain management
- * Toilet training
- * Encompresis
- * Enuresis
- * Social Skills Training
- * Behavior problems in hospital or at home
- * Consultation to hospital staff and community agencies.

In order to refer to Behavior Therapy there must be a reasonable basis to assume that the presenting problems have a behavioral component or alternatively, there is the need, as part of the multi-discipline investigation to examine possible behavioral contributions to complex symptomatology.

In terms of outpatients, the feasibility of using local resources should be examined in all cases.

- (4) Social-Emotional Service. This service includes psychodiagnostic assessment, consultation, therapy and counselling for children and adolescents presenting with social, personality and emotional problems and for the families of these children. Such problems

include reactions to parental separation and divorce, bereavement, depression, social skills difficulties, family dysfunction disease, post traumatic stress and gender identity issues. The form of therapy may be individual psychotherapy, group or family therapy. Three forms of parent groups are currently being organized in psychology. These include:

- A Group for single parents of hard to control children;
 - B Training group for parents of children diagnosed with Attention Deficit Hyperactivity Disorder; and
 - C Child Management Skill Training Program.
5. Clinical Neuropsychology Service. This service provides a comprehensive description of the child's ability, and relates this information to brain functioning. The information is then used to help plan programs for home.

Supervision

The Psychology Department at the Janeway Child Health Center was approved as the internship site by Dr. Ron Lehr and Dr. Linda Moxley-Haegert. Dr. Lehr was the academic supervisor from the Educational Psychology Division of the Faculty of Education at Memorial University and Dr. Linda Moxley-Haegert, Director of Psychology at The Janeway Child Health Center was the field supervisor. The internship took

place over a thirteen week period during the Fall Semester of 1993.

During the internship, services were provided by a full-time staff of four. Psychologists consisting of a director, and three psychologists whose specialized roles are as follows:

L. Moxley-Haegert

- Diabetic Team
- Oncology Crisis Intervention
- Neurology Team
- Family Therapy Referrals
- Preschool Referrals
- Outpatient Referrals
- Child Protection Program
- Social Skills and Parenting Group

S. Manocha

- Cystic Fibrosis Clinic
- Asthmatic Clinic
- Psychiatry Referrals from Dr. Nagpurkar/Dr. St. John
- Referrals for children with Attention Deficit Disorders
- Outpatient Referrals
- Add Parent Groups
- Social Skills and Parenting Group

S. Downey

- Learning/ Behavior Clinic
- Communication/Development
- Palate Clinic
- Down's and Dysmorphic Clinic
- Psychiatry Referrals from Dr. White/Dr. St. John
- Referrals for Sleep Disorders, Anxiety and Pain Management
- Outpatient Referrals
- Burn Treatment Team
- Chronic Pain Team (to be developed)

J. Lee

- Communication/Development Clinic
- Out patient Referrals

Behavior Therapy Services
Social Emotional Service
In patient Referrals
Psychiatry Referrals - Dr. St. John/Dr. White
Adolescent Survivors of Sexual Abuse
ADD Parent Group

Internship Goals

As stated in the Educational Psychology Internship Paper (1975),
"the purpose of the internship is to provide an extension of the practicum
and to develop a flexible program that provides:

1. For the development of competencies for each trainee based on his needs, previous experiences, and future vocational plans;
2. For practical experiences that will bring into focus the theoretical training received during the formal part of the program;
3. For practical experiences that will enable the trainee and the department to evaluate the trainee's ability to effectively work in a chosen field;
4. Opportunities for the trainee to evaluate his personal behavior modalities and work toward making any necessary changes;
5. For feedback from the internship setting to the department regarding strengths and weaknesses of its students so that program improvements can be implemented; and
6. For the development of research and problem-solving skills

appropriate to the needs of the students and the setting,

considering the nature of her placement and her vocational plans".

Based on the broad goals set by the Department of Educational Psychology and retained by the Educational Psychology section after faculty reorganization, the intern developed the following specific goals related to the chosen setting:

Goal 1: To gain an understanding and proficiency in the use of a wide variety of assessment techniques and tools. This goal was achieved through a variety of activities (Refer to Table 1).

A description of these activities is as follows:

- (1) Tests were administered to a variety of people who could be classified as inpatients and outpatients. Depending on the diagnosis or hospital placement of the people, preparation for testing varied. History taking for each person played a significant role in determining the type of assessment tool and the conditions under which such assessment devices were administered. There were occasions when testing had to be carried out over several periods when patients had difficulty attending to the task due to psychological, emotional or physical challenges or after administration of medication.
- (2) As a follow-up to the administration of assessment devices,

Table 1

Type and Frequency of Tests Administered During the Internship

Type of Test Administered	Frequency of Administration
Conners Behavior Rating Scale	6
Test of Written Language (TOWL)	3
Test of Non-Verbal Intelligence	3
Peabody Picture Vocabulary Test	3
Children's Personality Questionnaire	3
Children's Behavior Checklist	5
Bender Gestalt Test of Visual Interpretation	2
Mental Status Checklist for Children	2
Mental Status Checklist for Adolescents	4
Wechsler Preschool & Primary Scale of Intelligence	2
Wechsler Intelligence Scale for Children Third Edition	8
Developmental Test of Visual Motor Integration	1
Minnesota Multiphasic Personality Inventory	2
Beck Depression Inventory	2
Beck Hopelessness Inventory	2
Wide Range Achievement Test Revised I	6
Wide Range Achievement Test Revised II	4
Family Assessment Device	10

consultations with personnel in the psychology department, hospital school and psychiatry department were conducted. The purpose of these consultations was to obtain feedback and direction for the purpose of enhancing the intern's skill in administration and particularly in the interpretation of these assessment devices.

Given the wide variety of professional staff available for consultation, the depth and breadth of their input was invaluable.

The intern's confidence in the selection, administration, scoring, and interpretation of assessment tools increased as a result of the experience gained. Discussions with the staff permitted the intern to critically analyze the application of a variety of assessment tools.

- (3) Observations were made in various settings with individuals, in group settings and with family members. The patients referred to the Janeway Child Health Center for assessment represent a broad array of challenges including psychological, emotional, neurological, academic, physical, social, and behavioral. A common experience for all these referrals, is the school system. There are many occasions in the school when a counsellor feels his/her training is not sufficient to provide a student with the psychological/psychiatric or other help they require. On such occasion, it is important for the counsellor to have knowledge of suitable referral agencies. During

the internship, the student became aware of the speciality services for assessment available through the Janeway Child Health Center. As a result of the intern's experience with a wide variety of assessment tools, expertise was gained with less traditional types of assessment devices. This translates into a valuable experience as there are many occasions in the school setting when children/adolescents present with unusual problems. The intern's knowledge and competence with these devices enables her to more effectively assess the need for further intervention at a center such as the Janeway Psychology Department. This valuable experience enhances the intern's ability to carry out her role as a school guidance counsellor.

Goal 2: To become familiar with techniques of family therapy. During the course of the internship regular ongoing consultations were held with Dr. Linda Moxley-Haegert and Dr. Ron Lehr. Both practitioners have long standing experience in the area of Family Therapy and thus they were able to offer valuable experience to the intern regarding assessment technique and evaluation in Family Therapy. This expertise was accessed through a variety of activities as shown in Table 2.

Table 2

Type and Frequency of Activities Undertaken by the Intern to Develop Knowledge and Skills in Family Therapy Techniques

Activity	Frequency
Reading and discussions with Dr. Moxley-Haegert and Dr. Lehr on the text book Family System Therapy (Becvar & Becvar, 1993)	N/A
Observed counselling sessions - one-way mirror	5
Co-therapy with Dr. Moxley-Haegert	6
Individual and Family Therapy supervised by Dr. Linda Moxley-Haegert	4
Administration and Scoring of the Family Assessment Device	50
Use of the McMaster's Structured Interview with Clients	3
Videotaping of Family Therapy Sessions (For supervision purposes)	6
Supervision by Dr. Moxley-Haegert of Family Therapy Sessions	12 hours
Read articles in Family Therapy Journals (e.g. Michael White Family Therapy)	N/A
Attended a workshop on Family Therapy - Theory and Practise sponsored by the Association of Newfoundland Psychologists and acted as facilitator in small group sessions	1 day
Research Project in Family Therapy	N/A

A discussion of the activities to meet goal 2 is as follows:

- (1) Reading and discussion of a current text on Family Therapy with Dr. Moxley-Haegert and Dr. Ron Lehr. This text provides the

reader with a basic understanding of the historical context of family therapy. It presents the Systems Theory including content and process with a major emphasis on the application of this theory. As the intern did not have a theoretical background in family therapy, this text provided an excellent introduction to family therapy. Both Dr. Moxley-Haegert and Dr. Ron Lehr having used this text as their main resource in the teaching of a graduate course in family therapy, were familiar with the content and provided the intern with the opportunity for valuable discussion on the topic.

- (2) Observation of family therapy sessions through use of a one-way mirror and videotapes. These were followed by discussions with the therapists to process content and technique. Systemic Family Therapy and Michael White Family Therapy were the two theories most frequently used. It was interesting to note the differences in these two techniques and the value of each.
- (3) Participation as a co-therapist with Dr. Moxley-Haegert. These sessions were again followed by supervision. These sessions consisted of assessment using the McMaster Structured Interview and feedback to clients from the Family Assessment Device as well as the use of various techniques. The discussions which followed with Dr. Moxley-Haegert were very valuable in the development of

teaching skills. The intern, through the course of these sessions became familiar with the skills of engagement, assessment, therapy and termination which are critical components of the family therapy process.

- (4) Family Therapy sessions led by the intern were supervised by Dr. Moxley-Haegert with follow-up discussions on content and process. During the course of the internship, the intern read numerous articles referenced in the bibliography on the subject of Family Therapy and psychology of children and adolescents (see Appendix J). This was done in an effort to strengthen the theoretical foundation of the intern in the area of Family Therapy.
- (5) The intern attended a full day workshop on Family Therapy sponsored by the Association of Newfoundland Psychologists. This workshop provided a general overview of the various theories of Family Therapy as well as practical applications of these theories. The intern acted as a facilitator in small group sessions, which proved to be a very beneficial experience. During this workshop, the intern networked with many counsellors and therapists. The exchange of ideas and the contacts made were very valuable.
- (6) Observation and theoretical review of the McMaster Structured Interview followed by use of this assessment device under the

supervision of Dr. Moxley-Haegert.

- (7) Videotapes of Family Therapy sessions conducted by the intern were reviewed by and discussed with Dr. Moxley-Haegert. The purpose of these supervised sessions was to provide feedback on the direction, technique, and skills used by the intern. The intern found this to be very helpful especially in the identification of inappropriate responses by the therapist and the need for refocusing of approach.
- (8) The intern administered and scored 50 copies of the Family Assessment Device. A description of this device is included in the research component of the internship. The intern's familiarity with this assessment device will enable her to apply it in other settings for family therapy evaluation.
- (9) The intern conducted a research project which was ongoing throughout the internship. It provided an excellent learning opportunity in the theory and practise of Family Therapy in particular, the Systems Theory. It offered the intern an opportunity to gain knowledge of the Family Assessment Device as well as interview techniques with Family Therapy clientele. It also provided the Janeway Child Health Center with both quantitative and qualitative data to support the efficacy of delivering the service

of family therapy to their clients.

Goal 3: To gain an understanding and develop competency in the role as a psychologist in a medical center servicing children and adolescents. This goal was met through a variety of activities as shown in Table 3.

A discussion of the activities to meet Goal 3 is as follows:

- (1) Generally speaking, understanding and competency was established initially through the orientation process that involved reading of policy manuals followed by group and individual discussions with personnel in the Psychology Department and other departments of the Janeway Child Health Center. Job shadowing of the four psychologists in the Psychology Department also enabled the intern to gain a good understanding of the role of the psychologist in a medical setting.
- (2) Throughout the course of the internship, the intern attended psychiatry rounds, case conferences, team meetings of the Learning Behavior Clinic, Cystic Fibrosis Clinic, and Asthmatic Clinic. These sessions offered the intern many opportunities for incidental learning to occur. It also provided a better understanding of the inter-departmental operations of the hospital. It served as an opportunity to observe and practise management skills as the intern took an active role in the weekly psychology department meetings

Table 3

Type and Frequency of Activities the Intern Participated in to Develop Competency in Fulfilling the Role of a Psychologist

Activity	Frequency
Hospital Orientation	Sept. 30, 1993
Attended Psychiatry Rounds	weekly
Attended Case Conferences - Team consisted of Medical Personnel, Psychiatrists, Nurses, Social Workers, Hospital School Personnel, Parents, and Community School Personnel	bi-weekly
Attended Team Meetings of Learning Behavior Clinic, Cystic Fibrosis Clinic, and Asthmatic Clinic	N/A
Attended Teleconference on Eating Disorders	2 hours
Attended Suicide Counselling Workshop at the Waterford Hospital and Conducted Staff Inservice on Suicide Intervention and Prevention for the Psychology Department Staff	1.5 days
Peer Counselling Training with Adolescents	1 day
Served as a Consultant to Nursing Students and Educational Psychology Graduate Candidates on various topics	6 hours
Group/Individual Counselling and Report Writing was Supervised by Staff Psychologists	25 hours
Consulted with Donna Ronan- a specialist in the area of Child Abuse re: Therapy Programs	3 hours
Viewed 3 films on Child Abuse, Emotional Abuse, Physical Abuse, and Sexual Abuse. A follow-up discussion with social workers was held.	3 hours

where departmental business and patient intake occurred. The intern gained valuable experience in understanding quality control and evaluation

of services and programs. This knowledge can be transferred for use in the school setting as the intern takes an active role in the evaluation of many programs and services offered in the educational setting.

- (3) The intern attended a teleconference broadcasted from Toronto on the topic of Eating Disorders. Medical specialists in the area of Eating Disorders presented research and information on the topic of Bulimia and Anorexia. This was followed by a question and answer session with participants from a multi-disciplinary approach.
- (4) The intern attended a one-day workshop entitled "Beyond Crisis" held at the Waterford Hospital on counselling suicidal patients. A psychiatrist from Edmonton, Alberta specializing in suicide prevention and treatment conducted the workshop. This workshop was a follow-up to one offered by the Waterford Hospital on Suicide Intervention and Prevention. This workshop was extremely valuable as the intern felt a need for training in the therapeutic approaches for suicidal clients. Such clients are found in the school system as well as the hospital setting. The workshop had theoretical and practical components. The practical component was very basic; yet raised the intern's awareness of the need for ongoing and indepth training in this area. As a follow-up to this workshop, the intern conducted a staff inservice for members of the Psychology

Department on the topic of suicide assessment and treatment.

- (5) The intern conducted a Peer Counsellor Training Workshop for 40 adolescents in the St. John's area. This consisted of introductory counselling skills with a particular emphasis on peer tutoring. Evaluation of the workshop indicated the students and their supervisors found it to be enlightening, helpful, and enjoyable. The intern gained feedback which will be helpful in planning future Peer Counselling Workshops. There is usually the tendency to cram too much content into too short a time frame. In future, the intern will reduce the scope and concentrate on a smaller number of key skills.
- (6) The intern served as a consultant to several Nursing students and Educational Psychology Graduate candidates on a variety of topics including parenting programs, social skills development, peer counselling, and psychoeducational/psychiatric assessment.
- (7) The intern compiled individual, group, and family counselling reports under the supervision of the staff psychologists. The variety of report writing included psychiatric consultations, psychoeducational assessments, psychological assessment and group and family reporting. This provided the intern with an opportunity to practise writing reports on a wide spectrum of disorders and for a variety of purposes.

Goal 4: To enhance skills in group counselling. The intern carried out the following activities to meet this goal. These activities are presented in Table 4.

A discussion of the activities to meet Goal 4 is as follows:

- (1) The intern facilitated a Social Skills Group for inpatients and outpatients of the Psychology and Psychiatry Departments of the Janeway Child Health Center (see Appendix G). The group consisted of 10 patients and their families. The children ranged in age from 11 to 15 years. They were referred to the Social Skills Group by psychiatrists, social workers and psychologists at the hospital.

The group program consisted of nine sessions. A Social Skills group was run for the children each week for 8 sessions of 1½ hours duration. Concurrently, a parent group was offered to parents to address issues they had regarding their role as parents and their concerns for their children. Dr. Linda Moxley-Haegert facilitated the parenting group.

The sessions for the pre-teen group addressed issues of self-esteem, friendship, decision-making, assertiveness training, and relationship building. This nine week series is designed to help pre-adolescents and adolescents learn how to initiate and maintain positive relationships

Table 4

Type and Frequency of Activities Used to Develop Group Counselling Skills

Activity	Frequency
Facilitator of a Social Skills Group. Program was edited by Pam Turpin and Harsha Pujara. See Appendix H for a more detailed description of the program.	9 sessions
Facilitator of a Parenting Group developed by Russell Barkley to train parents in child management skills for dealing with defiant children.	9 sessions
Co-facilitator and Facilitator of Support Groups on Psychiatry (Separate groups were held for Adolescents, Children to age 12, as well as a combined group)	weekly
Co-facilitator/Facilitator of a Parenting Group for Parents of Preschoolers	9 sessions
Attended an Inservice for Parenting Program 1-2-3 Magic (Video and Manual)	½ day

with others. It's goals for participants are as follows:

1. To provide educational material on various social skills;
2. To practise acquired social skills through role plays and activity assignment;
3. To gain self-awareness;
4. To improve self-esteem and confidence building;
5. To reduce social isolation; and
6. To enjoy and have fun.

Attendance for the Social Skills Group and the Parenting Group was excellent. The introductory and final sessions were attended by all parents and their children. Evaluation of the program indicated that parents and their children believed it to be very successful and worthwhile as it attained the goals set out.

The Social Skills Program used was one edited by Pamela Turpin (1992) who had previously used the program. Pre and post self-esteem inventories administered showed improvement in the self-esteem of the participants especially in the areas of Home and Peer issues. This intern gained greater knowledge of group dynamics by facilitating this program. In future, the intern recommends reducing the age range of 11 through 15 years as this was too broad. The needs at various ages are so diverse that it is not probably to meet them in a 9 session program. Also, the intern believed group cohesiveness was more difficult to attain probable due to this great age range. See Appendix H for a description of the group sessions for this program.

- (2) The intern facilitated a Parenting Group for parents of children ages 3-6 years. This program entitled "Training Program for Defiant Children" by Russell Barkley (1987), was conducted over an 8 week period with a 1½-2 hour session per week. A follow-up

review session was held one month after the final session. The parents were chosen for the group program through psychology and psychiatry referrals. The program was designed particularly as a therapeutic clinical program for children exhibiting serious behavioral difficulties.

The group sessions involved assessment of behavior, understanding of behavior and temperament from Social Learning Theory and Genetics. The Interventions taught to parents included relationship building, listening skills, use of encouragement and praise in shaping behavior, time-out as a behavioral management technique and a token-economy system of behaviour management.

Most of the parents reported success with the program. They reported improvements in their children's behavior as well as improved skills for themselves. Several of the parents made friendships which they continued beyond the group sessions. This served as a source of support after the termination of the sessions. A follow-up session held one month following group termination indicated the parents were practising the skills learned. Several parents stated they had regressions in managing behavior but felt they were equipped with the skills to remediate this.

The philosophy of this program is a positive one. The program

promotes development of relationship with the child through "special time" spent with the child as well as use of encouragement, praise, and consequences. This approach diverted from many programs which concentrate on punishment. The intern sees that she will be able to use this program in her present school placement where there are children aged 4 through 15 years. The parenting program was supervised by Satinder Manocha who attended all sessions and provided supervision to the intern which was both focused and instructive.

- (3) The intern co-facilitated a second parenting group with Dr. Linda Moxley Haegert at a local day care parent-child center. The same program was used with parents of pre-school age children.
- (4) The intern co-facilitated or facilitated three Support Groups conducted on the Child/Adolescent Psychiatry Ward of the Janeway Hospital on a weekly basis throughout the internship. These support groups are ongoing groups for inpatients at the hospital. One group includes children to age 12 years, another group includes adolescents and the third group is a combined group for all inpatients of the Psychiatry ward. The purpose of these groups is to provide support and a forum for patients to address issues regarding their inpatient status. The group leader's responsibility consists of

facilitation of discussions and the structuring of therapeutic activities. These groups offered insight on individual and group issues and the process associated with such groups. The intern gained a deeper understanding of patients and the processes of psychiatric and psychological intervention. All the patients are students who attend school when they are not inpatients. This again offered the intern an opportunity to gain greater insight into the child/adolescent who is a student.

- (5) The intern attended a one-half day inservice by Janice Lee, a staff Psychologist. The inservice conducted was a Parenting Program entitled "1-2-3-Magic". A video and manual are used to conduct the program.

There are many occasions in the school setting when the counsellor addresses issues of parenting as a effective intervention for children and their families. This inservice program will be of great benefit to the counsellor in the school setting.

Goal 5: To enhance counselling skills by becoming familiar with various psychotherapy approaches. Clients were referred to the intern by all members of the Psychology Department as well as by Psychiatric Consultation. Each of the psychologists at the Janeway Child Health Center has expertise in a particular area of Psychology. This offered the

intern a broad range of experiences of a very valuable nature. The activities conducted to achieve this goal are listed in Table 5.

A discussion of the activities to meet Goal 5 is as follows:

- (1) The intern worked with Mr. Scott Downey, a staff psychologist specialized in Cognitive-Behavior Therapy, Behavior Modification, Relaxation Training, Attention Deficit Disorder, and Learning Disabilities. A number of patients were referred to the intern by Mr. Downey for individual therapy using a variety of psychotherapeutic methodologies. The intern observed Mr. Downey and then carried out therapies under his supervision. In particular, patients were taught Cognitive-Behavioral techniques for the management of pain, anxiety, phobias, and conduct disorders. Relaxation training was found to be effective with a large number of patients exhibiting a broad range of problems. The wide range use of these techniques will be useful to the intern in the school setting for use with individuals and groups. Mr. Downey has developed a very useful audiotape for relaxation training which can be utilized in a variety of setting including the school. As well his expertise in the area of Learning Strategies was a valuable resource for the intern which will have applicability in the school setting.

Table 5

Type and Frequency of Activities Participated in and the Number of Clients Seen by the Intern to Become Familiar with Various Psychotherapy Approaches.

Activity	# Clients	Therapy Plan
Pain Management	2	Relaxation Training Cognitive Behavior Therapy
Anxiety Management	5	Cognitive Behavior Therapy Relaxation Training
Management of Phobias	3	Systematic Desensitization Relaxation Training Cognitive Behavior Therapy
Psychoeducational Referrals	8	Assessment Consultation with Parents & School Personnel Learning Strategies
Conduct Disorders	3	Behavior Modification Family Therapy
Attention Deficit Disorder	4	Information Sharing Group Counselling Medication Therapy Behavior Modification
Grief Therapy	N/A	Observed Therapist Reading Materials

- (2) Another valuable activity the intern engaged in at the Janeway was that of assessment of patients using individual patient, parent and combined patient-parent interviews. The intern observed and conducted such interviews under the supervision of all the staff psychologists. The supervision and follow-up of specific treatment

modalities broadened and enriched the intern's repertoire of counselling and therapy techniques.

- (3) The intern had the opportunity to observe and work with Mr. Satinder Manocha who has particular expertise in the areas of Behavior Modification, Attention Deficit Disorder, as well as several medical conditions. This experience allowed the intern to understand more fully the intricacies of these disorders and interventions that only observation and practise can provide. The Parent Support Program for children with Attention Deficit Disorder devised by Mr. Manocha is a worthwhile group therapy program. Knowledge of this program will be of great benefit to the intern upon returning to the school setting as many children are initially identified through school personnel.
- (4) The intern became familiar with a specialized program of Grief Therapy practised by Dr. Linda Moxley-Haegert. This therapy consists of three sessions with parents and patients with positive results. The intern identified this program as a good program for use in the school system as children often experience losses while attending school. If this is not dealt with properly, it can have negative effects on the child's ability to achieve.

GOAL 6: To conduct a research component in which the clients' and

therapist's perceptions of success in family therapy will be measured. A pre and post test administration of the Family Assessment Device (FAD) was administered in conjunction with an interview questionnaire for both the therapist and the adult clients in Family Therapy. This will be described in more detail in Section 2 of the internship report.

Conclusion

The Janeway Child Health Center Psychology Department offers an excellent opportunity for a student in the Educational Psychology Masters Degree Program to develop knowledge and skills in counselling beyond that which could be achieved from a practicum placement alone. The internship provided the intern with exposure to a variety of learning experiences in developmental psychology, clinical evaluation and treatment, behavior therapy services, social and emotional counselling and clinical neuropsychology services and family therapy. The practical experience gained from supervised activities greatly improved the intern's competence in a wide range of counselling areas. The intern had the opportunity to observe the expertise of many staff members thus providing a very enriching experience. The internship has been very beneficial in that it provided an arena for the intern to develop both personally and professionally.

The next chapter of this internship comprises a research study

conducted at the Janeway Child Health Center. It evaluates the effectiveness of family therapy as perceived by clients and therapist.

CHAPTER 2

Introduction

To fulfil the requirements for the counselling internship in the Master Degree Program in Educational Psychology at Memorial University of Newfoundland one must undertake a research project appropriate to the particular internship setting. At the Janeway Child Health Center, Family Therapy is a service offered to families. Referrals for this service come from: clients; staff psychologists; hospital social workers; the psychiatry department; and outside agencies.

The researcher encounters many families in her present position as a counsellor/therapist in an elementary-junior high school. Most of the problems students present often have a family dynamic component. Family systems theory suggests that in order to treat a problem, the entire family unit must be involved. If this approach is not adopted, then the therapist is merely treating a symptom of a problem. In order to be effective within a school setting, a counsellor/therapist should utilize the knowledge gained from family therapy research.

Research on both the process and outcomes of family therapy has come to occupy a significant and permanent place in the field of family therapy. Today there is great interest in investigating the effectiveness of various forms of family therapy with different populations. With such

diversity in family structure present in North American society, it is imperative that both children's hospitals and the schools be equipped with the knowledge and skills necessary to put family therapy research into practice. In order to provide the most effective form of family therapy, it is imperative to examine clients' and therapists' views of success in therapy. By examining how clients and therapists perceive success of family therapy, insight will be gained into appropriate programming for therapy. This will be the central focus of this internship research study.

Statement of Purpose and Rationale

The usefulness of the helping process has been the target of debate for several years. A pivotal question has been "Does professional helping really help" i.e. is therapy effective? One way to answer this question is to evaluate the effectiveness of therapy as viewed by both clients and therapists. By evaluating the effectiveness of family therapy, a feedback mechanism will be built into the therapeutic process and in turn, provide the therapist with insight into possible changes that may need to be made in order to make counselling successful.

Gurman, Kniskern and Pinsof (1986) state, "by the middle of this decade (1980) it was clear that ...marital and family therapy had demonstrated its general efficacy." This reaffirms the conclusion of earlier reviews and is also in accord with the majority of review articles cited by

Gurman, Kniskern and Pinsof (1986) and by German and Pinsof (1978, 1981). In summarizing the Gurman and Kniskern (1978) article for their 1986 readership, Gurman, Kniskern and Pinsof (1986) write,

"non behavioral marital and family therapy produce beneficial outcomes in about two-thirds of cases and their effects are superior to "treatment"...positive effects typically occur in treatment of short duration, that is 1-20 sessions...family therapy is probably as effective and possibly more effective than many commonly offered (usually individual) treatments for problems attributed to family conflict...".

Some of the criticisms leveled at family therapy research by Raffa, Sypek and Vogel (1990) include methodological problems. It appears that the investigation of effectiveness should include therapist and client input (Williams & Miller, 1981).

Since it is important to be constantly mindful of cost, clearly it is a useful clinical exercise to consider when we should and should not offer family therapy. Clinical impressions are valuable but they are not the be all and end all. According to Lask (1980), we do not know which families to treat, therefore we must evaluate our work so that eventually we can be objectively certain that the expenditure of time, energy and emotion is justified. Lask also notes that a determination to evaluate our work automatically causes us to ask what constitutes improvement.

According to Llewelyn & Hume (1979), an essential task of evaluation is the comparison of clients and therapists beliefs and

observable results at the end of therapy and follow-up. Feifel & Ells (1963) point out that a patient's viewpoint is a valuable contribution to our understanding of the therapy process.

The purpose of this study was to investigate and compare clients' and therapists' perceptions of the efficacy of family therapy. This study will provide valuable information for the planning of services for both the school and hospital settings.

Research Questions

The following research questions were developed for this study:

1. Does family therapy improve family functioning as perceived by clients?
2. Does family therapy improve family functioning as perceived by therapists?
3. Do clients and therapists concur on the outcome of family therapy?
4. How do clients view satisfaction of family therapy?
5. Do clients and therapists concur on their identification of problems which bring families to therapy?
6. Do clients and therapists concur on the reasons for success or lack of success in family therapy?

Literature Review

Throughout the current and past decade there has been

considerable debate over the efficacy of family therapy as an intervention strategy for improvement in family functioning. In the last fifteen years the rate of growth of outcome research in family and marital therapy has been phenomenal. The very first reviews of outcome research by Wells (1972) identified only thirteen reports. In 1973, Gurman identified fifteen studies with 726 cases. By 1978, Gurman and Kniskern examined 200 reports.

Inherent in all schools of family therapy is the belief that intimate relationship systems function to maintain symptoms and that families therefore represent potential therapeutic resources. According to this systems perspective, the potential for change is significantly increased through the involvement of intimates in plans for intervention. The family as a whole rather than its individual members receives the attention from the family therapist. The relationship system is the focus of therapy rather than any symptom of an individual member. The therapist focuses on the relationship system which support such problematic symptoms.

The last few decades have seen a tremendous rate of growth in outcome research in family and marital therapy. One of the main questions repeatedly asked by proponents of family therapy is, "How effective is family therapy?" This question has been answered in the results of several studies which suggests that such treatments are often

effective beyond chance. The applications for family therapy has been shown with disorders such as alcoholism, drug abuse, childhood conduct problems, work and school phobias, psychosomatic symptoms, and schizophrenia.

Studies of alcoholic families have indicated a significant reduction in drinking behavior when a spouse was involved in the treatment process (Cadigan; Corder et al.; Hedberg & Campbell; McCrady; cited in Russell, 1983).

Families with members addicted to drugs have also been examined by family therapy researchers. A very common family treatment has been conjoint family treatment (Russell et al., 1983). Stanton et al. (cited in Russell, 1983) did a 6-month post-treatment follow-up study and found family treatment to be 1.4 to 2.7 times as effective as other forms of therapy in producing days free from opiate, non-opiate drugs and alcohol use. Family therapy was also effective in reducing conflict and involving fathers more in family interactions. The results of this study documented change in both symptom and system functioning.

In a series of studies at the University of Utah investigating the application of family therapy to offenses committed by juveniles, Alexander et al. (cited in Russell, 1983) provided documentation for the following: (1) differences in the content and process of communication in the families of

soft-core delinquents (e.g. running away from home, promiscuity, and curfew violation) and controls; (2) modification of family communication; and (3) a lower rate of the identified patient recidivism and sibling referral.

Family therapy has also been used to help with childhood conduct problems. Family programs developed by the Oregon Research Institute have been proven as effective change methods for families of children with conduct problems including: hyperactivity, fighting, lying, stealing, bed-wetting, non-compliance of authority, whining and yelling (Patterson & Cobb; Taplin & Reid cited in Russell, 1983).

Pilman et al. (Cited in Russell, 1983) was successful in using insight-oriented crisis family therapy to help partners deal with work phobias. Skynner (Cited in Russell, 1983) reported an 85% success rate with school phobias using a family therapy intervention approach.

Using structural (Minuchin et al., 1974, 1978) and strategic (Palazzoli, 1974) family therapy techniques, therapists have documented impressive outcomes in the treatment of patients with anorexia nervosa, brittle diabetes, and asthma. Using structural family therapy, with 53 anorectic families, Minuchin and his colleagues reported an 86% recovery rate. Sixteen different therapists were involved in the therapy and outcome was evaluated in terms of remission of anorectic symptoms (i.e. weight gain) and psychosocial functioning in relations to home, school and peers.

Another method which has gained recent attention to investigate the efficacy of family therapy is the use of meta-analysis. Meta-analysis provides a "highly quantitative method for integrating research results and yielding conclusions" (Markus et al., 1990). In their 1987 review, Hazelrigg et al. examined 20 studies with controls. Their analysis suggested that family therapy had positive effects compared to no-treatment and alternative treatment controls as measured by family interactions and behavior ratings. These effects however were diminished and more variable when assessed at a post treatment interval.

Subsequent to the Hazelrigg et al study, Markus et al. (1990) also performed a meta-analysis. Although 10 of their 19 studies were used in the Hazelrigg et al. study, Markus et al. did find proof for the effectiveness of family therapy in their meta-analysis. Of the studies they statistically analyzed, at post treatment they found the average patient who participated in family therapy was better off than 76% of patients who received alternate treatment, a minimal treatment, or no treatment. Once again however, these effects tended to diminish after an extended period of time elapsed (e.g. 18 months).

It is the opinion of some researchers that there is merit in offering family therapy to different populations of clients, and that what needs to be investigated now are the more specific details of family therapy. As

seen in this brief literature review, there has been an abundance of research in the area of family therapy outcome. The results of this research have contributed a great deal to answering many of the questions regarding efficacy of family therapy. A logical step in future research appears to be in the tightening of methodological procedures for evaluating success. In order to address some of these methodological concerns plaguing this area. Gurman and Kniskern (1981) stated, "We believe that there is no need for further detailed reviews of the outcome literature...what is needed in our opinion is not a remastication of what has already been digested but a redirection and re-focus toward identifying what needs to be studied in the future and toward identification of the clinically most relevant questions needing answers" (p.243).

Asen, Bekowitz, Cooklin, Leff, Loader, Piper & Rein (1991) argue that while the need for family therapy research has been widely acknowledged, many debates continue on the questions of what constitutes valid research and how it should be implemented. One of these questions concerns the research methodology in terms of what method of evaluation is most suitable to determine efficacy of family therapy.

In the past, clients' self reports and objective questionnaires were used independently to determine success in family therapy. Paolino and McCrady (1978) state that "client self report measures are useful and

informative indices of therapeutic change. However, client reports of increased marital satisfaction must be viewed with appropriate scepticism, since such reports of improvement may be determined by a variety of factors other than actual changes". For example, such improvements may be due to the clients' desire to please the therapist.

Cline, Jackson, Klein, Mejia, & Turner (1987) suggest that measuring therapist and client perceptions using both self reports and objective questionnaires (such as the Family Assessment Device (FAD) or the Marital and Communication Inventory (MCI)) improve the research methodology and therefore increase the reliability of the results.

As stated by Lask (1980), if any therapy is to be taken seriously it must be shown to be useful. There is little point in doing something time-consuming, costly, and emotionally demanding, if it has not therapeutic value. Showing the usefulness of any type of service requires an evaluation of it. The questions of what and how to evaluate family therapy are central to its evaluation as an effective therapy choice for families.

Chase & Holmes (1990) used case notes of a therapist to evaluate the success of family therapy. In a meta-analysis study, Markus et al. (1990) used mostly objective measures of symptom intensity and frequency. Some evaluation studies distinguish between first and second order change made within family therapy where first order refers to symptom

improvement and second order concerns are organized or structured in relation to the problem (Stevenson, 1993). Lask (1980) suggested that, "system improvement is always accompanied by symptom improvement but that the reverse is not always the case". The Mental Research Institute (MRI) group argue that first order change is adequate. Bennun (cited in Stevenson, 1993) supports this view however, he suggested that second order change should still be evaluated. Towns & Seymour (cited in Stevenson, 1993) propose that family therapy research should include a measure of change in family interaction so that a considered decision can be made about its importance.

Frude (1980) believes that the family's perspective is a valuable indicator of success in therapy since client satisfaction is the ultimate goal. In their research, some researchers such as Speed (cited in Stevenson, 1993) compared the subjective evaluation of the therapist with that of family members.

Considerable debate in this area has also centered around the appropriateness of qualitative versus quantitative research. As with any quantitative study, supporting data provides evidence for the utility of the program of choice. Others believe that there is richness in information derived qualitatively (Bryman cited in Stevenson, 1993). Commenting on this issue, Rice and Greenberg state the following,

"such an approach might help us to understand more about what happens between the client and therapist and consequently about how therapy works or fails to work" (Rice & Greenberg, cited in Stevenson, 1993).

The research study undertaken as part of this intern's requirement for the Graduate Program in Educational Psychology will combine the findings of Gurman, Kniskern and Pmsos (1986), Chase and Holmes (1990), Speed (1985), Markus et al. (1990), Stevenson (1993), and Frude (1980) to investigate and evaluate the effectiveness of family therapy through objective questionnaires which determine symptom intensity and change as well as clients' qualitative self-reports at follow-up. This information combined with therapists' reports of perceived effectiveness of therapy will provide valuable information for the internship setting which can be used for future planning.

Methodology

This study was a retrospective study of families who had received family therapy services at the Janeway Child Health Center within the past two years. A group of families who had received family therapy and who had completed pre and post family therapy questionnaires were administered a self-report inventory. The therapists for these clients were also administered a compatible self-report inventory. These were administered to both parties between two months to one year following

therapy. Both the pre- and post FAD questionnaires and self-reports of clients and therapists were analyzed to determine perceived changes as a result of therapy. The data from the FAD was available in the files of these clients in the Psychology Department of the Janeway. The self-reporting inventories were administered through personal interview by the researcher. Information on gender, age, number of children, number of therapy sessions, and reason for termination of therapy was collected for descriptive purposes only and not for analysis.

Sample

The sample consisted of 9 families who had received family therapy within the previous two years at the Janeway Child Health Center. These families were chosen from the files at the Janeway Psychology Department. They were chosen because they had completed a pre-therapy Family Assessment Device. Three therapists who provided therapy for these families were also included in the sample. These families included adults and their children who were aged 12 or above who had completed pre therapy assessments. There were a total of 26 clients of which 17 were parents and 9 were children. The adults ranged in age from 33 years to 47 years. The children ranged in age from 13 years to 20 years. Of the adults, 9 were female and 8 were male. Of the children, 6 were female and 3 were male. Families received an average of 8 therapy sessions.

Clients were referred from a variety of sources for therapy. These included the hospital Psychiatry Department, schools, Family Physicians and self-referrals. The reasons for these referrals included behavioral and/or emotional difficulties of the children.

Instruments

Two instruments were used in this study. These included the Family Assessment Device (FAD) (see Appendix A) and a therapy outcome questionnaire designed specifically for this investigation (see Appendices B & C respectively). These questionnaires were devised based on a previously developed instrument used by Dr. Ron Lehr in a family therapy outcome study of couples. A question on each of the follow-up questionnaires matched the Family Assessment Device for the first six dimensions.

The FAD is based on the McMaster Model of Family Functioning (MMFF), a clinically oriented conceptualization of families. The FAD was constructed to collect information on the various dimensions of the family system as a whole, and to collect this information directly from the family members. It describes structural and organizational properties of the family group and the patterns of transactions among family members which have been found to distinguish between healthy and unhealthy families.

The FAD is made up of seven scales, one, General Functioning,

assesses the overall health/pathology of the family. The other 6 assess the 6 dimensions of the MMFF. It is a paper and pencil questionnaire which can be filled out by all family members over the age of 12. The 60 items in the questionnaire are statements a person could make about his/her family. Each family member rates his/her agreement or disagreement with how well an item describes his/her family by selecting among the four alternative responses: strongly agree, agree, disagree, and strongly disagree. The questionnaire takes approximately fifteen to twenty minutes to complete. The field supervisor Dr. Linda Moxley-Haegert had permission to duplicate the copyrighted Family Assessment Device, the manual, scoring sheet, instructions and Family Information Form (see Appendix G).

The McMaster Model identifies 6 dimensions of family functioning. They are: Problem Solving: the first dimension of the MMFF, refers to the family's ability to resolve problems (issues which threaten the integrity and functional capacity of the family) at a level that maintains effective family. Seven steps of effective problem solving are identified. Communication is the second dimension of the MMFF. It is defined as the exchange of information among family members. The focus is on whether verbal messages are clear with respect to content and direct in the sense that the person spoken to is the person for whom the message is intended. Roles is the third dimension. Here the MMFF focuses on

whether the family has established patterns of behavior for handling a set of family functions which include provision of resources, providing nurturance and support, supporting personal development, maintaining and managing the family systems and providing adult sexual gratification. Also, assessment of the Roles dimension includes consideration of whether tasks are clearly and equitably assigned to family members and whether tasks are carried out responsibly by family members. Affective Responsiveness, the fourth dimension, assesses the extent to which individual family members are able to experience the appropriate affect over a range of stimuli. Affective Involvement is the fifth dimension. It is concerned with the extent to which the family members are interested in, and place value on, each other's activities and concerns. The healthiest families have intermediate levels of involvement, neither too little nor too much. Behavior Control is the final dimension of the MMFF, and assesses the way in which a family expresses and maintains standards of behavior of its members. Behavior in situations of different sorts (dangerous, psychological and social) is assessed as are different patterns of control (flexible, rigid, laissez-faire and chaotic are considered).

The psychometric properties of the FAD have been researched with Psychiatric and Medical Populations. Kabacoff et al. (1990) completed a psychometric study using data obtained from large clinical, nonclinical, and

medical samples. Internal scale reliabilities and factorial validity were assessed for each group and results compared across groups. The results from the study add to the accumulating data concerning the psychometric properties of the FAD. Scale reliabilities were favourable and the hypothesized factor structure of the FAD was supported.

Design and Analysis

This study sought to determine the success of family therapy by using previously completed FAD data taken both before and after family therapy intervention. Comparisons were made on the FAD data using t-tests. A follow-up questionnaire was issued by the researcher to both clients and therapists. Some of the data from the follow-up questionnaire was presented in descriptive terms. Consent for the use of this data in a research study was obtained from the families and therapists involved as well as the Janeway Child Health Center. All parties were informed about the confidentiality of this data.

Results

The purpose of this study was to evaluate and compare clients' and therapists' perceptions of the efficacy of family therapy using the FAD and a follow-up questionnaire. An analysis of the pre- and post therapy administrations of these instruments was carried out using t-tests.

Table 6 shows the results of the paired differences of the seven

dimensions of the FAD. Results of this analysis indicated a significant improvement in three of the following dimensions: Problem Solving ($t=.041$, $p<.05$); Behavior Control ($t=.017$, $p<.05$); and General Functioning ($t=.026$, $p<.05$). Overall, clients' post therapy scores indicated a significant improvement in their ability to solve problems, control problematic behavior, and function as a family. Although respondents scores on the remaining 4 dimensions did not achieve statistical significance, improvement occurred on all of these dimensions.

Table 7 shows the percentage of clients who indicated improvement on the 7 dimensions of the FAD following therapy. The average percentage of improvement on the 7 dimensions was 62. As indicated 12 out of 26 or 46 percent of the respondents reported overall improvement in family functioning on all 7 dimensions of the FAD. Of the seven dimensions scored, Affectiveness Responsiveness was the dimension most often reported (72%) as having improved.

In the follow-up questionnaires Appendices B and C, there was a high degree of agreement between clients and therapists regarding outcome of therapy. As shown in Table 8, therapists' ratings of success in therapy (e.g. very successful and somewhat successful) on six dimensions of the FAD ranged from 72 percent to 100 percent. The average percentage of success as perceived by therapists was 62 percent when calculated using

Table 6

Family Assessment Device - Statistical Analysis Of Paired Differences.

Dimensions	Mean	SD	t-value	df	p
Problem Solving	.3192	.757	2.15	25	.041 *
Communication	.1962	.592	1.69	25	.103
Roles	.0538	.433	.63	25	.532
Affective Response	.2692	.697	1.97	25	.060
Affective Involvement	.0038	.481	.04	25	.968
Behavior Control	.3269	.651	2.56	25	.017 *
General Functioning	.3077	.664	2.36	25	.026 *

Significance * $p < .05$

the "Very Successful" category alone and 87 percent when calculated using both the "Very Successful and "Somewhat Successful" categories. The most notable ratings of success pertained to the dimensions of Communication, Behavior Control and Problem Solving.

As shown in Table 9, a similar trend was found with respect to clients' perceptions of success on 6 dimensions of the FAD. In addition to overall success (i.e. combined categories of "Very Successful" and "Somewhat Successful") on the dimensions Communication, Behavior Control and Problem Solving clients reported an extremely high degree of success (greater than 85 percent). Of all the dimensions, Affective Responsiveness was rated most successful with a score of 95 percent

Table 7

Percentage of Clients Showing Improvement on the 7 Dimensions of the FAD.

Dimensions of the FAD	Percentage Showing Improvement
Problem Solving	62%
Communication	65%
Roles	54%
Affective Responsiveness	73%
Affective Involvement	58%
Behavior Control	65%
General Functioning	61%
Mean = 62 %	

following therapy. In general, 5 of the 6 dimensions showed a combined "Very Successful" and "Somewhat Successful" score above 81 percent. The lowest combined score was on the dimension Roles which was 71 percent.

In comparing clients' and therapists' ratings in the "Very Successful" category alone, it was evident that Behavior Control and Communication were the two highest rated dimensions. Clients rated Behavior Control and Problem Solving respectively as showing the greatest improvement in the "Very Successful" category. Tied for third were Communication, Roles and Affective Involvement.

Table 8

Therapists' Perceptions of Clients Success on Six Dimensions of the FAD Following Therapy as a Function of Percentage of Clients Showing Improvement.

Dimension	Very Successful	Somewhat Successful	Not Successful
Problem Solving	72	14	14
Communication	86	14	0
Roles	57	29	14
Affective Responsiveness	28	48	24
Affective Involvement	44	28	28
Behavioral Control	86	14	0
	Mean = 62	Mean = 25	Mean = 13

N = 21

Table 10 presents a comparison of clients' and therapists' ratings of success in family therapy. Overall, the results suggest that therapists and clients reported a very high degree of success in therapy. The combined ratings of "Very Successful" and "Somewhat Successful" indicated that therapists reported success for 91 percent of the clients assessed. Clients self-reported success in family therapy in 87 percent of the cases.

As shown in Table 11, clients were asked to rate their overall satisfaction with family therapy. The results indicated that 33 percent of clients were very satisfied and 48 percent were satisfied with family therapy. Clients reported they were not satisfied in 19 percent of cases.

Table 9

Percentage of Clients Who Perceived Success on Six Dimensions of the FAD Following Therapy.

Dimension	Very Successful	Somewhat Successful	Not Successful
Problem Solving	29	57	14
Communication	19	72	9
Roles	19	52	29
Affective Responsiveness	14	81	5
Affective Involvement	19	62	19
Behavior Control	33	48	9
	Mean = 22	Mean = 62	Mean = 14
N = 21			

Overall, 81 percent of clients indicated that there were satisfied or very satisfied with therapy.

The results yielded answers to several important questions. The mean number of therapy sessions was eight.

Included among the reasons most frequently given for referral to family therapy were: behavioral difficulties with children; lack of ability to solve problems; and communication problems. Both clients and therapists concurred on these three main reasons for referral. Clients also mentioned inability of family members to share feelings as another reason for referral.

Table 10

A Comparison in Percent of Clients and Therapists Overall Rating of Therapy Outcome.

Rater	Very Successful	Somewhat Successful	Not Successful
Therapists	56	35	9
Clients	26	61	13

N = 23

Clients and therapists were asked what accounted for success or failure of therapy. Of the 81 percent of clients who reported success in therapy, 27 percent attributed therapist understanding and caring as the primary reason for success. Twenty-two percent indicated improved communication skills and the opportunity to "talk things out" with a third and objective person as the second most important reason for success.

Of the 19 percent of clients who reported no success, reasons given included: inability of family members to open up; masking or unclear goals at the onset of therapy; and lack of communication among family members.

Therapists indicated that their primary reason for success in therapy was the client's commitment to change and their "hard work". Therapists stated that the main reason for failure in family therapy was due to family members inability to open up and unwillingness to communicate true feelings. Early termination of therapy was the reason given for failure of

Table 11

Clients' Ratings in Percent of overall Satisfaction With Family Therapy.

Rater	Very Satisfied	Satisfied	Not Satisfied
Clients	33	48	19

N = 23

therapy for one family.

Discussion

This study demonstrated that clients and therapists concurred on the effectiveness of family therapy. The results of the Family Assessment Device and Follow-up questionnaires jointly demonstrated the efficacy of family therapy. This supports the view of Cline et al. (1987) who argue the need for measuring client and therapist perceptions of family therapy outcome using both self-reports and objective questionnaires. As stated by Cline et al., this increases the reliability of the results hence, the results of this study gained added reliability due to its adoption of this methodology. This study provided reliable input in determining the value in offering family therapy as a beneficial program at the Janeway Child Health Center Psychology Department. This supports Lask's (1980) argument for the importance any therapy program to provide support for its therapeutic value, cost effectiveness, and investment of emotional and physical resources.

In this study, clients reported improvement on all 7 dimensions of the FAD. Although only three dimensions reached statistical significance, there was an average improvement in 62 percent of cases. Compared pre- and post score differences on the FAD with matched questions on the follow-up questionnaires indicated agreement among clients and therapists on both instruments. These results suggest validity in the reporting of efficacy of the therapy services offered to clients. Both Problem Solving and Behavior Control were dimensions that clients and therapists reported as having improved as determined by a combined rating of success categories. This was supported by the results of the FAD which showed statistically significant improvements on these particular dimensions. Given that 87 percent of clients and therapist in 91 percent of client cases indicated some degree of success in therapy, it was concluded that therapists and clients perceived therapy as successful.

In agreement with Bryman (Cited in Stevenson, 1993) qualitative information was gained from this study. In concurrence with Rice and Greenberg (cited in Stevenson, 1993), this study found that valuable information added in understanding what happens between clients and therapists and consequently about how therapy works or fails to work.

The reasons clients and therapists gave for success in therapy were similar. Therapists believed clients to be committed to change and

learning new skills including the ability to open up and to communicate better.

There was mutual agreement between clients and therapists on the reasoning for lack of success in therapy. Clients and therapists expressed their respect for each other by statements made on the follow-up questionnaires. Clients stated that understanding and caring on the part of the therapist was very helpful in bringing about success. Therapists reported clients commitment to making improvements for their families.

This study indicated that family therapy is an effective intervention offered at the internship setting. There is merit in using methodology which combines both qualitative and quantitative data. The researcher acknowledges the limitations of the generalizability of the results due to limits in sample size. Further investigations may include a comparison of individual versus family therapy interventions for their effect on family functioning. Research in the area of symptom versus system change would provide valuable information. As well, to gain insight into what actually happens during therapy, in-session analysis of clients' and therapists' behaviors could provide beneficial input into family therapy research.

This internship has provided the intern with an excellent opportunity for professional development and personal growth. The broad range of activities in which the intern participated enhanced her knowledge

and skills in the field of counselling. The newly acquired skills and knowledge are generalizable to the intern's school of employment. The intern anticipates she will be able to initiate parenting groups, social skills groups, and family therapy sessions in the school setting. More extensive assessments will be conducted as a result of the knowledge gained through the internship.

The research component provided the intern with the opportunity to expand the research base in family therapy combining client and therapist perceptions of therapy outcome. The implications and limitations of this study were discussed. Through this study the intern gained valuable experience with the process of counselling evaluation which is an essential component of the therapeutic process. It also provided the internship setting with feedback for future programming.

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APPENDIX A
Family Assessment Device



BROWN UNIVERSITY *Providence, Rhode Island • 02912*

Division of Biology and Medicine

BROWN/BUTLER FAMILY RESEARCH PROGRAM

INSTRUCTIONS FOR COMPLETING THE FAMILY ASSESSMENT DEVICE

1. Each member of your family, over the age of 12, should complete a FAD.
2. Please respond to the items in terms of how you feel your family has been functioning in the past two months.
3. Complete the FAD privately; away from other family members.
4. Do not discuss your responses with your family members.
5. We are interested in your personal view of your family.

INSTRUCTIONS FOR COMPLETING THE FAMILY INFORMATION FORM

1. We also require general information about your family. To help us with this, we ask that either the Husband/Father or Wife/Mother complete the Family Information Form.

When you have completed the Family Assessment Device (FAD) and the Family Information Form, please return to _____.



**FAMILY
ASSESSMENT
DEVICE**

Version 3

Nathan B. Epstein, M.D.
Lawrence M. Baldwin, Ph.D.
Duane S. Bishop, M.D.

The Brown University Butler Hospital Family Research Program

Butler Hospital

345 Blackstone Boulevard

Providence, Rhode Island 02906

Date of Administration: _____

Family Role: _____

Identification Number or Family Name: _____

INSTRUCTIONS:

This booklet contains a number of statements about families. Please read each statement carefully, and decide how well it describes your own family. You should answer according to how you see your family.

For each statement there are four (4) possible responses:

Strongly Agree (SA)

Check SA if you feel that the statement describes your family very accurately.

Agree (A)

Check A if you feel that the statement describes your family for the most part.

Disagree (D)

Check D if you feel that the statement does not describe your family for the most part.

Strongly Disagree (SD)

Check SD if you feel that the statement does not describe your family at all.

These four responses will appear below each statement like this

41 We are not satisfied with anything short of perfection.

_____ SA _____ A _____ D _____ SD _____

The answer spaces for statement 41 would look like this. For each statement in the booklet, there is an answer space below. Do not pay attention to the blanks at the far right-hand side of each answer space. They are for office use only.

Try not to spend too much time thinking about each statement, but respond as quickly and as honestly as you can. If you have trouble with one, answer with your first reaction. Please be sure to answer every statement and mark all your answers in the space provided below each statement.

1. Planning family activities is difficult because we misunderstand each other.
_____ SA _____ A _____ D _____ SD _____
2. We resolve most everyday problems around the house.
_____ SA _____ A _____ D _____ SD _____
3. When someone is upset the others know why.
_____ SA _____ A _____ D _____ SD _____
4. When you ask someone to do something, you have to check that they did it.
_____ SA _____ A _____ D _____ SD _____
5. If someone is in trouble, the others become too involved.
_____ SA _____ A _____ D _____ SD _____
6. In times of crisis we can turn to each other for support.
_____ SA _____ A _____ D _____ SD _____
7. We don't know what to do when an emergency comes up.
_____ SA _____ A _____ D _____ SD _____
8. We sometimes run out of things that we need.
_____ SA _____ A _____ D _____ SD _____
9. We are reluctant to show our affection for each other.
_____ SA _____ A _____ D _____ SD _____
10. We make sure members meet their family responsibilities.
_____ SA _____ A _____ D _____ SD _____
11. We cannot talk to each other about the sadness we feel.
_____ SA _____ A _____ D _____ SD _____
12. We usually act on our decisions regarding problems.
_____ SA _____ A _____ D _____ SD _____

13. You only get the interest of others when something is important to them.
_____ SA _____ A _____ D _____ SD _____
14. You can't tell how a person is feeling from what they are saying.
_____ SA _____ A _____ D _____ SD _____
15. Family tasks don't get spread around enough.
_____ SA _____ A _____ D _____ SD _____
16. Individuals are accepted for what they are.
_____ SA _____ A _____ D _____ SD _____
17. You can easily get away with breaking the rules.
_____ SA _____ A _____ D _____ SD _____
18. People come right out and say things instead of hinting at them.
_____ SA _____ A _____ D _____ SD _____
19. Some of us just don't respond emotionally.
_____ SA _____ A _____ D _____ SD _____
20. We know what to do in an emergency.
_____ SA _____ A _____ D _____ SD _____
21. We avoid discussing our fears and concerns.
_____ SA _____ A _____ D _____ SD _____
22. It is difficult to talk to each other about tender feelings.
_____ SA _____ A _____ D _____ SD _____
23. We have trouble meeting our bills.
_____ SA _____ A _____ D _____ SD _____
24. After our family tries to solve a problem, we usually discuss whether it worked or not.
_____ SA _____ A _____ D _____ SD _____

25. We are too self-centered.

_____ SA _____ A _____ D _____ SD _____

26. We can express feelings to each other.

_____ SA _____ A _____ D _____ SD _____

27. We have no clear expectations about toilet habits.

_____ SA _____ A _____ D _____ SD _____

28. We do not show our love for each other.

_____ SA _____ A _____ D _____ SD _____

29. We talk to people directly rather than through go-betweens

_____ SA _____ A _____ D _____ SD _____

30. Each of us has particular duties and responsibilities.

_____ SA _____ A _____ D _____ SD _____

31. There are lots of bad feelings in the family.

_____ SA _____ A _____ D _____ SD _____

32. We have rules about hitting people.

_____ SA _____ A _____ D _____ SD _____

33. We get involved with each other only when something interests us

_____ SA _____ A _____ D _____ SD _____

34. There's little time to explore personal interests.

_____ SA _____ A _____ D _____ SD _____

35. We often don't say what we mean.

_____ SA _____ A _____ D _____ SD _____

36. We feel accepted for what we are.

_____ SA _____ A _____ D _____ SD _____

37. We show interest in each other when we can get something out of it personally.
_____ SA _____ A _____ D _____ SD _____
38. We resolve most emotional upsets that come up.
_____ SA _____ A _____ D _____ SD _____
39. Tenderness takes second place to other things in our family.
_____ SA _____ A _____ D _____ SD _____
40. We discuss who is to do household jobs.
_____ SA _____ A _____ D _____ SD _____
41. Making decisions is a problem for our family.
_____ SA _____ A _____ D _____ SD _____
42. Our family shows interest in each other only when they can get something out of it.
_____ SA _____ A _____ D _____ SD _____
43. We are frank with each other.
_____ SA _____ A _____ D _____ SD _____
44. We don't hold to any rules or standards.
_____ SA _____ A _____ D _____ SD _____
45. If people are asked to do something, they need reminding.
_____ SA _____ A _____ D _____ SD _____
46. We are able to make decisions about how to solve problems.
_____ SA _____ A _____ D _____ SD _____
47. If the rules are broken, we don't know what to expect.
_____ SA _____ A _____ D _____ SD _____
48. Anything goes in our family.
_____ SA _____ A _____ D _____ SD _____

49. We express tenderness.

_____ SA _____ A _____ D _____ SD _____

50. We confront problems involving feelings.

_____ SA _____ A _____ D _____ SD _____

51. We don't get along well together.

_____ SA _____ A _____ D _____ SD _____

52. We don't talk to each other when we are angry.

_____ SA _____ A _____ D _____ SD _____

53. We are generally dissatisfied with the family duties assigned to us.

_____ SA _____ A _____ D _____ SD _____

54. Even though we mean well, we intrude too much into each others lives

_____ SA _____ A _____ D _____ SD _____

55. There are rules about dangerous situations

_____ SA _____ A _____ D _____ SD _____

56. We confide in each other

_____ SA _____ A _____ D _____ SD _____

57. We cry openly.

_____ SA _____ A _____ D _____ SD _____

58. We don't have reasonable transport.

_____ SA _____ A _____ D _____ SD _____

59. When we don't like what someone has done, we tell them.

_____ SA _____ A _____ D _____ SD _____

60. We try to think of different ways to solve problems.

SA A D SD

APPENDIX B**Client Follow-up Questionnaire**

Name: _____

Number of Therapy Sessions: _____

Gender: _____

Age: _____

Referral Source: _____

Occupation: _____

- (1) What was the most important problem that brought you to family therapy?

- (2) Were there other problems? Yes ____ No ____

- (3) If yes please list them. _____

- (4) How would you rate the outcome of therapy?

Very Successful ____

Somewhat Successful ____

Not Successful ____

- (5) If there was success, what do you think brought it about?

-
- (6) If there was no success, what do you think was the cause of it?
-
-

- (7) Of the issues stated below, how much of a problem were they to your family?

1 - Not at all

2 - Somewhat of a problem

3 - A definite problem

4 - A serious problem

___ **Problem Solving** (Ability to resolve your families problems)

___ **Communication** (Ability to share ideas and information)

___ **Roles** (Tasks members of your family do on a regular basis)

___ **Affective Responsiveness** (Ability to respond to other family members with appropriate quantity and quality of feelings)

___ **Affective Involvement** (The extent to which the family shows interest in and values the interests of individual family members)

___ **Behavior Control** (Standards and rules your family maintains)

- (8) Please rate how much success you feel you had in improving the following issues:

1 - Very Successful

2 - Somewhat Successful

3 - Not Successful

___ **Problem Solving** (Ability to resolve your families problems)

___ **Communication** (Ability to share ideas and information)

___ **Roles** (Tasks members of your family do on a regular basis)

___ **Affective Responsiveness** (Ability to respond to other family members with appropriate quantity and quality of feelings)

___ **Affective Involvement** (The extent to which the family shows interest in and values the interests of individual family members)

___ **Behavior Control** (Standards and rules your family maintains)

(9) How would you rate your overall satisfaction with family therapy?

1 - Very Satisfied

2 - Satisfied

3 - Not Satisfied

APPENDIX C**Therapist Follow-up Questionnaire**

Therapist Name: _____

Name of Clients: _____

- (1) What was the most important problem that brought this family to counselling? _____

- (2) How would you rate the success of therapy?

Very Successful _____

Somewhat Successful _____

Not Successful _____

- (3) If there was success, what do you think brought it about?

- (4) If there was no success, what do you think was the cause of this?

- (5) Please rate how much success you feel these clients had in improving following issues:

1 - Very Successful

2 - Somewhat Successful

3 - Not Successful

- ___ **Problem Solving** (Ability to resolve your families problems)
- ___ **Communication** (Ability to share ideas and information)
- ___ **Roles** (Tasks members of your family do on a regular basis)
- ___ **Affective Responsiveness** (Ability to respond to other family members with appropriate quantity and quality of feelings)
- ___ **Affective Involvement** (The extent to which the family shows interest in and values the interests of individual family members)
- ___ **Behavior Control** (Standards and rules your family maintains)

APPENDIX D**Janeway Child Health Center Research Consent Form**

JANEWAY CHILD HEALTH CENTRE
HUMAN INVESTIGATION COMMITTEE

APPLICATION FORM

This form is intended as a convenience to speed up the processing of applications to the Committee. It was designed to cover as large a variety of proposals as possible. Where questions are not applicable to a particular proposal, please enter N/A. If space provided is not adequate for your purpose and it is necessary to add further information, please submit this in single-spaced typing, indicating clearly to which question it refers.

Where investigators feel that their proposal involves a matter of manifest triviality only, they should consult with the Chairman or Secretary of the Committee to ascertain whether a short statement on the proposed investigation would be acceptable.

1. Name(s) of Investigator(s):

2. Name of Supervisor in case of student applicant(s):

3. Title of Investigation:

4. List of Hospitals/Community
Setting Involved:

<u>Check Type of Involvement</u>		
<u>Patients</u>	<u>Records</u>	<u>Facilities</u>

5. State, briefly, objectives of the investigation:

6. Which of the following are to be employed in the investigation:
- (a) Samples to be taken from subjects: State type of sample, frequency and amount. Would samples be taken especially for this investigation or as part of normal patient care?
 - (b) Questionnaires: To whom will they be administered? How will confidentiality be maintained? Attach copy of questionnaire to be used.
 - (c) Clinical trials: State drugs, dosage and route of administration. Will this be experimental therapy _____, cross over comparison _____, double blind trial _____, placebo _____, other(specify)_____.
7. Scientific background: (If necessary, attach another sheet of paper). If this investigation has been done previously with human subjects, why repeat it? If it has not been done with humans before, has the problem been worked out as fully as possible in animals, both to perfect analytical, technical and to assess possible toxic effects?
8. Number of subjects: _____ State how they will be selected. Will pregnant subjects be excluded?

9. Number of controls: _____ State how they will be selected.
10. Give a brief description of the design of the study.
11. Describe the procedures and any tests or substances to be administered to patients (special diets, drugs, isotopic tracers, etc.)
12. What risks and discomforts are involved in the study?
13. What benefits can be anticipated from the study?
14. Are there any immediate benefits arising out of the study for the subjects? (specify)
15. Is there any invasion of privacy? _____ If yes, what steps will be taken to preserve confidentiality?

16. Explain the procedure for obtaining the subject's consent, where appropriate. Where applicable, attach copy of (a) consent form, and (b) explanation of the investigation which will be given to the subject/guardian.
17. Will subjects include minors _____, mentally incompetent persons _____, legally incompetent persons _____? If so, what steps will be taken to protect their rights?
18. What will be the mechanism for debriefing or feedback to subjects?
19. What is the probable date of completion of the study?
20. Will volunteers receive reimbursement for expenses _____ or payment for participation _____, in the study? Please specify.
21. Will any tangible benefit, financial or otherwise, be derived from the investigation by the investigator or the institution?
22. Will data become the exclusive property of the pharmaceutical company or other outside agency?

23. It is the responsibility of the investigator to ensure that permission is obtained from clinicians, departments, institutions or communities whose patients/residents will be involved in the study? Have appropriate contacts been made?
24. Are there any costs or extra time implications for our hospital or hospital personnel? If yes, please specify.
25. Do you have funding for this research? If yes, please specify source.
26. All approved projects are for scientific study and clinical appraisal. Release of research/project findings requires the prior approval of the hospital's Executive Director.

Date of Submission: _____

Signature of Principal Investigator

Signature of Supervisor in case of student application

APPENDIX E
Client Consent Form

APPENDIX E
CLIENT CONSENT FORM

Dear _____

I am a graduate student in the Faculty of Education at Memorial University. At present I am doing an internship with Dr. Linda Moxley-Haegert in the Janeway Psychology Department. As part of my internship I am conducting a research project under the supervision of Dr. Ron Lehr, of Memorial University.

In my research I am interested in determining the success of family therapy as clients and therapists see it.

I am requesting that you give permission for you/your child to participate in this study. I will be asking you to complete the Family Assessment Device which you completed at the beginning of Family Therapy as well as a brief questionnaire. I will be using the results of your previous Family Assessment Device to compare changes in the present scores. Dr. Linda Moxley-Haegert will also be asked to complete a questionnaire similar to the one you will be completing.

All information gathered in this study is strictly confidential. No family or individual will be identified individually. Participation is voluntary and you or your child may withdraw at any time. This study has received the approval of the Faculty of Education's Ethics Review Committee and the Janeway Human Investigation Committee. The results of my research will be made available to you upon request.

If you are in agreement with having yourself/your child participate in this study, please sign below. If you have any questions or concerns please do not hesitate to contact me at 754-0784. If at any time you wish to speak with a resource person not associated the study, please contact Dr. Patricia Canning, Associate Dean, Research and Development at Memorial, 737-3402.

Thank you for your consideration of this request.

Yours sincerely,

BETTY LOU KENNEDY

I _____ (parent/guardian) hereby give permission for myself/my child to take part in a study on the success of family therapy undertaken by Betty Lou Kennedy. I understand that participation is entirely voluntary and that my child and/or I can withdraw permission at any time. All information is strictly confidential and no individual will be identified.

DATE

PARENTS/GUARDIANS SIGNATURE

WITNESS

APPENDIX F**Therapist Consent Form**

A research project is being conducted at the Janeway Child Health Center by Betty Lou Kennedy, a graduate student of the Educational Psychology Faculty at Memorial University of Newfoundland. This research is being supervised by Dr. Linda Moxley-Haegert, Director of the Psychology Department at the Janeway Child Health Center and Dr. Ron Lehr, Professor of Educational Psychology at Memorial University of Newfoundland. The purpose of this research is to investigate the usefulness of the McMaster Family Assessment Device (FAD) - a questionnaire designed to evaluate families according to the McMaster Model of Family Functioning, to determine the degree to which clients' and therapist perceptions of success in family therapy agree.

I understand that for the purpose of analysis results will identify families by a code number. I understand that any publication arising from the research will not present individual results but only general report findings. I am aware that the questionnaires will remain in the family's clinic file. I have been shown the questionnaire and have my questions answered. I know that I may contact Ms. Kennedy at 754-0784 to discuss any further questions I may have about this research. I understand that my participation in this research is entirely voluntary. I know that I may withdraw from this research at any time. Please note that this project has been approved by the Ethics Committee of Memorial University as well as by the Human Investigations Committee of the Janeway Child Health Center.

I hereby give my permission to participate in this research.

(Signature of Client)

(Date)

(Signature of Witness)

APPENDIX G**Copyright Permission For Use Of
The Family Assessment Device**

Enclosed please find the FAD packet that you ordered. You have permission to duplicate the copyrighted Family Assessment Device, the manual scoring sheet and instructions, and the Family Information Form. We may contact you in the future to receive your feedback on the instrument.

Thank you for your interest and good luck in your future project.

Sincerely,

Ivan W. Miller, Ph.D.
Director
Brown University Family
Research Program
Butler Hospital
345 Blackstone Blvd.
Providence, R. I. 02906

IWM/

Enclosure

APPENDIX II**Getting Along With Others****A Social Skills Group For Teens**

Group Counselling Program for a Social Skills Group for Teens.	
Session 1	Introduction
Session 2	Building Self-Worth: "I am Special"
Session 3	Communication
Session 4	The Decision-Making Process: How to Make Thoughtful Decisions
Session 5	Saying "No" to Peer Pressure: Assertiveness Versus Aggressiveness
Session 6	Understanding and Learning to Deal with Conflict
Session 7	Friendship and Dating
Session 8	Evaluation and Celebration
Session 9	Debriefing

APPENDIX I

List of Books and Articles Read During Internship

- American Psychiatric Association. (1987). Diagnostic and Statistical Manual of Mental Disorders (3rd Ed.). Washington, D.C.: American Psychiatric Association.
- Barkley, R. (1987). Defiant Children: A Clinicians Manual. New York: The Guildford Press.
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